General

The bureaus under the Office of Audit and Recovery are responsible for conducting auditing and monitoring reviews of Medicaid providers. Those bureaus include: Financial and Performance Audit, Program Integrity, and Third Party Recovery. It is the mission of the Office of Audit and Recovery to ensure compliance, efficiency, and accountability within the Mississippi Medicaid program by detecting and preventing fraud, waste, program abuse, and by ensuring that Medicaid dollars are paid appropriately by implementing tort recoveries, pursuing recoupment, and identifying avenues for cost avoidance.

Audit and Monitoring Reviews

The Office of Audit and Recovery utilizing bureau staff, contracted audit entities or combination of both, selects Medicaid providers for review. An audit or monitoring review has the following objectives:

1. To determine if services billed and paid under the State's Medicaid program were:
    - Provided to an eligible beneficiary;
    - Medically necessary;
    - Provided at the appropriate level of care;
    - Appropriately documented;
    - In accordance with the Mississippi Medicaid Provider Manual, Mississippi State Plan, and official notices through other means such as, but not limited to, the Mississippi Medicaid Provider Bulletin, Remittance Advice header messages, and official communications from the Agency; and
    - For service for which the reimbursement rate is based on a cost report, that the cost report contains only allowable costs and were completed in accordance with the Mississippi Medicaid Provider Manual and Mississippi State Plan.
2. To provide a systematic and uniform method of determining compliance with state and federal program rules and regulations
3. To provide a mechanism for data gathering which can be used to modify the State's Medicaid program and State Medicaid Policies and Procedures;
4. To determine if the services provided meet the community standard of care; and
5. To determine if the provider is maintaining clinical and fiscal records which substantiate claims submitted for payment during the review period.

Audit Methods and Locations

The Office of Audit and Recovery selects the appropriate method of conducting the review including, but not limited to, the following:

1. On-site reviews, conducted on the provider's premises;
2. Desk audits, conducted at DOM's or Contracted auditor's offices; or
3. A combination of an on-site and a desk audit.

Audit/Monitoring Review Overview

Audits/Monitoring reviews will involve the examination of the provider's medical and/or financial records. Providers must maintain appropriate documentation in the client's medical or health care service records to verify the level, type, and extent of services provided. Providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client;
- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains; and
- Make charts and records available to Medicaid staff, it contractors, and the U.S. Department of Health and Human Services upon request. Records shall be maintained in accordance with Mississippi Medicaid Provider Policy Section 7.03.

A provider's bill for services, appointment books, accounting records, or other similar documents alone do not qualify as appropriate documentation for services rendered.

If a provider fails to participate or comply with DOM's audit process or unduly delays the audit process, DOM considers the provider's actions or lack thereof, as abandonment of the audit.

If DOM suspects a provider of fraud, abusive practice, audit abandonment, or presents a risk of imminent danger to clients, DOM may take one or more of the actions listed below.

1. Immediately issue a final report;
2. Terminate the provider's agreement with Medicaid;
3. Issue a subpoena for the provider's records
4. Refer the provider to the appropriate prosecuting authority.

Audit/Monitoring Review Process

In general, the audit/monitoring review process will be as follows:

- **Provider Notification** – Generally, DOM will provide written notice of the audit/review thirty (30) calendar days prior to commencement of the audit/review. Exceptions to the thirty day advance notice requirement include, but are not limited to:
  - Resident trust fund reviews;
  - Desk reviews;
  - The provider is suspected of fraud or abuse; or
  - DOM believes that the provider's actions endanger the health or safety of patients or others.

  The notification will detail the program being reviewed, the audit period(s), the Medicaid provider number(s) and a documentation/materials request list. The documentation/materials request list will detail the information that will need to be submitted prior to the commencement date and the documentation that will be required once Audit and Recovery staff is on-site.

  The provider notification will also detail the number of audit/review staff that will be on-site and the expected timeframe of the audit/review. Providers are expected to accommodate audit/review staff with acceptable workspace.

- **Field Entrance Conference** – A field entrance conference will be held with designated provider staff. During the entrance conference, the lead auditor/reviewer for DOM will discuss the audit/review process, the requested documentation, workspace, provider contacts for questions/information requests, and any other items deemed necessary.

- **Procedures for Submitting Documentation Electronically** – Providers are required to follow all HIPAA regulations regarding the use and disclosure of Protected Health Information (PHI). If a provider chooses to submit documentation electronically, it must be submitted through DOM's secure website to protect PHI. Providers should contact Audit and Recovery with any questions on proper procedures for submitting documentation electronically.

- **Examination of Documentation** – During the review, audit/review staff will review requested documentation. Once on-site, audit/review staff will request additional documentation necessary to complete the audit/review. Providers are expected to provide information requested in timely manner.

- **Field Exit Conference** – At the conclusion of the on-site review, audit/review staff will conduct a field exit conference with designated provider staff. During the exit conference, the lead auditor/reviewer for DOM will discuss as appropriate, proposed adjustments and/or findings. All proposed adjustments/findings are subject to review prior to issuance of the final report. If additional information is required, Audit and Recovery staff will submit to the provider a documentation request list and a timeline for providing the information. Providers will have a maximum of two (2) weeks from the field exit conference date to produce additional files and records. Upon review of the outstanding documentation, if it is determined that additional items are needed; the provider will have a maximum of two (2) weeks from the date of notification to submit the documentation.

- **Draft Report** – Upon completion of the review of all documentation submitted by the provider, DOM will issue a draft report to the provider detailing the proposed adjustments and/or findings. The provider has thirty (30) calendar days from the date of delivery to submit a response to the adjustments and/or findings. The provider shall submit their response and additional documentation to DOM Audit and Recovery by certified mail, return receipt requested, overnight delivery by a private carrier, or by hand delivery. In their response, if the provider is contesting any adjustments or findings, their response should:

    - Specify which adjustments/findings are being contested; and
    - Supply documentation to support the provider's position.

  During the thirty (30) day response time, the provider may submit questions in writing to DOM. Requests for time extensions must be in writing and are not guaranteed.

  DOM will review the provider's response and any additional documentation provided. DOM will prepare a response to the provider and inform the provider of any changes that were made or an explanation will be provided if no changes were made. DOM will also contact the provider to schedule an exit conference. The exit conference will be held within 10 business days of contact by DOM.

  If the provider does not respond to the draft report within thirty (30) days, DOM will offer the provider an opportunity for an exit conference. In addition, DOM will issue the final report to the provider.

- **Exit Conference** – An exit conference will be held with the provider to communicate the results of the audit and the adjustments and/or findings that will be in the final report.

- **Final Report** – DOM will issue a final report to the provider via certified mail, return receipt requested. The final report will detail all adjustments and findings resulting from the review. The report will include a letter informing the provider of their rights to an administrative hearing.

- **Administrative Hearings** – Administrative hearings will be conducted in accordance with Section 7.06 of the Mississippi Medicaid Provider Manual.